THE FEDERAL BUREAU OF PRISONS
ANNUAL REPORT ON SUBSTANCE ABUSE TREATMENT PROGRAMS
FISCAL YEAR 2008

REPORT TO THE CONGRESS

As Required by the Violent Crime Control and Law Enforcement Act of 1994

January 2009

TABLE OF CONTENTS

INTRODUCTION

The Federal Bureau of Prisons (BOP) has prepared this report for the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives as required by 18 U.S.C. § 3621(e)(3). This report provides the following:

- A description of the process of identifying offenders with drug abuse treatment needs;
- A description of substance abuse treatment programs in the BOP; and
- The BOP's compliance with the requirements of Subtitle T of Title III of the Violent Crime Control and Law Enforcement Act of 1994, Substance Abuse Treatment in Federal Prisons, in terms of
  - meeting the demand for treatment;
  - providing an early release for appropriate offenders who successfully complete the residential drug abuse treatment program; and
  - coordinating with the Department of Health and Human Services.

IDENTIFYING OFFENDER TREATMENT NEEDS

Consistent with the research and literature on drugs and crime, the BOP has identified two types of incarcerated drug offenders based on their respective treatment needs:

Drug defined offenders are individuals whose violation of the drug laws is based on a business venture – they tend to be motivated solely by financial gain. These individuals may or may not need drug abuse treatment, but may benefit from other types of intervention.

Drug related offenders are individuals who violate the law as a direct result of their drug use. Their illegal activity may be a drug offense (such as possession of illegal substances) or it may be an offense committed to support their continued drug use (such as stealing to get money to buy

illegal drugs). These individuals are likely to need and benefit from drug abuse treatment.

The BOP uses the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) to analyze the extent and nature of an inmate's drug use. (See Attachment I for DSM definitions). Inmates who meet the DSM criteria for a drug use disorder (abuse or dependence) are referred to the BOP's intensive Residential Drug Abuse Treatment Program. Inmates who are found to have a drug "problem" are referred for Nonresidential Drug Abuse Treatment or for Drug Education. This parallels community drug abuse treatment regimens and differentiates between residential treatment and out-patient treatment.

At the time of an inmate's admission to a BOP facility, a staff psychologist reviews the inmate's case for any history of drug use. If it is determined that the inmate could benefit from drug abuse treatment, the inmate is referred to the institution's drug abuse treatment coordinator, who will further assess the inmate's need for treatment. If appropriate, the drug abuse treatment coordinator will refer the inmate for Residential Drug Abuse Treatment, Nonresidential Drug Abuse Treatment, or Drug Abuse Education.

To estimate the demand and determine the number of beds required for the Residential Drug Abuse Treatment Program each year, the BOP analyzed a portion of data that were collected as part of a study of the prevalence of mental health conditions in the inmate population. These data characterize samples of inmates from admissions cohorts during fiscal years 2002 and 2003. The BOP reviewed over 2,500 presentence investigation reports to ascertain the frequency of inmates with a drug use disorder (based on either a reference to a medical diagnosis of a drug use disorder or an inmate's self report of drug use that met the criteria for a drug use disorder). The findings extrapolated from these data indicate that approximately *40 percent of inmates entering BOP custody during fiscal years 2002 and 2003 met the criteria for a substance use disorder.*

DRUG ABUSE TREATMENT PROGRAMS IN THE BUREAU OF PRISONS

Drug Abuse Education

Drug abuse education is not drug abuse treatment. The purpose of drug abuse education is to encourage offenders with a history of drug use to review the harmful consequences of their choice to use drugs and how those choices have effected them physically, socially, and psychologically. Drug abuse education takes the offender through the cycle of drug use and crime and offers compelling evidence of how continued drug use can lead to a further criminality and related consequences. Drug abuse education is designed to motivate appropriate offenders to participate in nonresidential or residential drug abuse treatment, as needed.

Overview and Admission Criteria

Upon entry into a BOP facility, staff assess an offender's records to determine if an offender is suited for drug abuse education. The criteria used for this determination include: evidence that the offender has a prolonged history of alcohol or drug use, evidence that alcohol or drug use contributed to the commission of the instant offense, a judicial recommendation for treatment, or a violation of community supervision as a result of alcohol or drug use.

Program Content

Drug abuse education is offered at every BOP institution. Participants in drug abuse education review their individual drug use histories and are shown evidence of the nexus between drug use and crime. Participants also receive information on what distinguishes drug use, abuse, and addiction. Appropriate participants are referred for nonresidential drug abuse treatment or residential drug abuse treatment.

In the last year, the BOP released a revised drug abuse education protocol to further emphasize the relationship between drug use and criminal activity and the impact drug use has on interpersonal relationships. The streamlined protocol will allow Psychology Services personnel to spend more time providing drug abuse treatment to inmates.

In fiscal year 2008, 23,230 inmates participated in drug abuse education. (See Attachment II for a breakdown of participants by program and fiscal year.)

Nonresidential Drug Abuse Treatment

Nonresidential drug abuse treatment is available in every BOP institution through the Psychology Services Department, which is staffed with at least one Drug Abuse Program Psychologist and one Drug Abuse Treatment Specialist. Nonresidential drug abuse treatment is a flexible program designed to meet the treatment needs of all inmates.

Overview and Admission Criteria

Specific populations targeted for nonresidential drug abuse treatment include:

- Inmates with a relatively minor or low-level substance abuse impairment;
- Inmates with a drug use disorder who do not have sufficient time to complete the intensive Residential Drug Abuse Treatment Program;
- Inmates with longer sentences who are in need of treatment and are awaiting placement in the residential program;
- Inmates identified with a drug use history who did not participate in the Residential Drug Abuse Treatment Program and are preparing for community transition; and
- Inmates who completed the unit-based component of the Residential Drug Abuse Treatment Program and are required to continue with "aftercare" treatment upon their transfer back to the general inmate population.

The BOP is revising its treatment protocols for nonresidential drug abuse treatment to be consistent with changes made to the residential treatment program (as described in the section on the Residential Drug Abuse Treatment Program). Cognitive behavioral therapy will remain the core of the treatment model, focusing on an inmate's criminal and cognitive thinking errors and the need for developing positive attitudes, beliefs, and behaviors. (The success of the BOP's Residential Drug Abuse Treatment Program

is due in large part to the cognitive behavioral therapy treatment model).

Inmates participate in nonresidential drug abuse treatment for a minimum of 12 weeks and for a minimum of 4 hours per week. Treatment staff might increase these minimum requirements depending upon the needs of the inmate and the ability of the institution to provide services.

Nonresidential drug abuse treatment in the form of aftercare is required for inmates who have completed the unit-based component of the Residential Drug Abuse Treatment Program and who are not immediately transferred to a residential reentry center. This aftercare treatment is conducted for a minimum of 1-1/2 hours per week for 12 months or until his/her transfer to a residential reentry center.

Program Content

Nonresidential Drug Abuse Treatment uses the cognitive behavioral therapy treatment model, which is described in detail in the section on the Residential Drug Abuse Treatment Program.

A drug abuse treatment specialist, under the supervision of a psychologist, develops an individualized treatment plan based on a psycho-social assessment of the inmate. Self-help groups, such as Alcoholics Anonymous and Narcotics Anonymous, are available to inmates to support the BOP's nonresidential treatment regimen.

In fiscal year 2008, 14,208 inmates participated in Nonresidential Drug Abuse Treatment. (See Attachment II for a breakdown of participants by fiscal year).

Residential Drug Abuse Treatment

The Residential Drug Abuse Treatment Program (RDAP) was originally developed in 1995 based on the correctional drug abuse treatment research and literature of that time. Since 1995, the BOP has enhanced the program, incorporating treatment approaches that are based on the cognitive behavioral therapy treatment model. At present, 59 BOP institutions operate an RDAP, as does one facility under contract with the BOP. (See Attachment III for program locations).

Overview

The RDAP provides intensive drug abuse treatment to inmates diagnosed with a drug use disorder (based on the DSM criteria mentioned above). The programs are staffed by a doctoral-level psychologist (the Drug Program Coordinator) who supervises the treatment staff. The ratio of drug abuse treatment staff to inmates is 1 to 24.

Inmates in the residential program are housed together in a treatment unit that is set apart from the general population. Treatment is provided for a minimum of 500 hours over 9 to 12 months, consistent with drug abuse treatment research on program effectiveness.

Admission Criteria

Prior to acceptance into an RDAP, inmates are interviewed and assessed to determine if they meet the diagnostic criteria for a substance use disorder set forth in the DSM.

Inmates must enter residential treatment voluntarily and must sign an agreement to participate in the RDAP and abide by the rules regarding the behavior that is expected within and outside the treatment unit.

Participants are informed of how the BOP measures treatment success and what behaviors are required to successfully complete the RDAP. Treatment staff emphasize that the primary purpose of the program is to treat inmates for drug abuse, not to provide an early release from BOP custody.

Qualified inmates are admitted to RDAP based on their release date to ensure that all eligible inmates who are diagnosed with a drug use disorder and volunteer for residential treatment: (1) receive such treatment before they are released from custody, and (2) continue treatment with a community-based treatment provider as they transfer to a residential reentry center.

Inmates are admitted to the program when they have sufficient time left to serve to allow them to complete the unit-based component and the community transition drug abuse treatment phase of the program.

Program Content

The BOP's RDAP adheres to a cognitive behavior therapy treatment model. This treatment model targets the major criminal/

drug-using risk factors, especially anti-social and pro-criminal attitudes, values, beliefs, and behaviors. The BOP targets these behaviors by reducing anti-social peer associations; promoting positive relationships; increasing self-control, self-management, and problem solving skills; ending drug use; and replacing lying and aggression with pro-social alternatives. Treatment includes the development of a specific transition plan.

To date, the RDAP modules have been requested by all 50 States and 7 foreign countries, as well as a number of local correctional agencies and community-based treatment providers. The *RDAP Facilitator's Guide* is available through the National Institute of Corrections Information Center to assist treatment providers in the use of the BOP's residential drug abuse treatment modules.

The BOP continually reviews the research and literature on correctional treatment programs to ensure that the agency is making use of the best available techniques and strategies. Over the last year, the BOP has begun implementing a modified therapeutic community model for the RDAP to complement the cognitive behavior therapy treatment model. The agency expects that the modified therapeutic community model will be fully implemented in approximately 3 years.

In fiscal year 2008, 17,523 inmates participated in the Residential Drug Abuse Treatment Program. (See Attachment II for a breakdown of participants by fiscal year).

Treatment Evaluation

Beginning in 1991, in coordination with the National Institute on Drug Abuse, the BOP conducted a rigorous 3-year outcome study of the Residential Drug Abuse Treatment Program. The results were published in 2000 within reports on the study known as *Treating Inmates Addiction to Drugs (TRIAD)*. The evaluation was superior to any drug abuse treatment assessment to that point because of the size of the treatment population assessed, the opportunity to evaluate the effect of treatment on both male and female inmates (1,842 men and 473 women), and a methodology developed to address the problem of selection bias found in other evaluations.

According to the analysis, male participants are 16 percent less likely to recidivate and 15 percent less likely to relapse than similarly-situated inmates who do not participate in residential drug abuse treatment for up to 3 years after release. The analysis also found that female inmates are 18 percent less likely to recidivate than inmates who do not participate in treatment.

This study demonstrates that the BOP's Residential Drug Abuse Treatment Program makes a positive difference in the lives of inmates and improves public safety following the inmates' release from custody.

Community Transition Drug Abuse Treatment

Community Transition Drug Abuse Treatment has been a component of the BOP's drug abuse treatment strategy since 1991. All inmates who participate in the RDAP are required to participate in the Community Transition Drug Abuse Treatment component to successfully complete the RDAP.

Upon completion of the unit-based portion of the RDAP, the BOP ensures that inmates receive a continuum of treatment and supervision when the inmate is transferred to a residential reentry center. Research has shown that, with the continuum of supervision and treatment, the chances of relapse or other behavioral problems decrease dramatically, thereby reducing the likelihood of an offender's return to custody.

New data on "desistance" (an eventual permanent abstention from criminal behavior), underscores the importance of the initial period after release from prison. This is the riskiest time for both the public and the inmates themselves. The BOP continues to promote sustained abstinence from drugs to help ensure the successful reentry of ex-inmates back into the community.

The BOP uses residential reentry centers to place inmates in community-based settings prior to their release from custody to help them adjust to life in the community and find suitable post-release employment. These centers provide a structured, supervised environment and support in job placement, counseling, and other services.

Inmates continue their regimen of drug abuse treatment within the structure of the residential reentry center with a community-based treatment provider under contract with the BOP. The inmate must continue to participate in community transition drug abuse treatment or he/she will be returned to custody and will lose the residential program's incentives (e.g., early release).

In FY 2008, the BOP has provided treatment for offenders with co-occurring disorders (such as a drug use disorder and a mental illness) during this period of transition. Sex offenders with substance use disorders received community transition treatment that combines supervision along with continued drug abuse treatment while residing in the residential reentry center.

Inmates who have not participated in drug abuse treatment in an institution, but who are found to have a drug use disorder as they near release or during their placement in a residential reentry center, could be required to participate in community-based drug abuse treatment as part of their program plan. The BOP terms this provision of drug abuse treatment as "enhanced treatment service" and provides this service to ensure that all inmates in need of drug abuse treatment have the opportunity to participate in treatment while in BOP custody.

An important component of Community Transition Drug Abuse Treatment is the transfer of information from institution treatment staff to the BOP's regional transition teams. Institution drug abuse treatment specialists provide regional transition teams with a treatment summary that includes information on the inmate and his/her program involvement while in BOP custody. The regional transition team forwards these reports to the contract drug abuse treatment provider and the United States Probation Office.

To further the continuum of treatment, participants in community transition drug abuse treatment often continue drug abuse treatment during their period of supervised release under the auspices of the United States Probation Office. These inmates frequently remain with the same treatment provider, ensuring continuity in treatment

and accountability during this period of community reentry and supervision.

In fiscal year 2008, 15,466 inmates participated in Community Transition Drug Abuse Treatment. (See Attachment II for a breakdown of participants by fiscal year).

COMPLIANCE WITH THE REQUIREMENTS OF THE VIOLENT CRIME CONTROL AND LAW ENFORCEMENT ACT OF 1994

Meeting the Demand for Treatment

Subtitle T of Title III of the Violent Crime Control and Law Enforcement Act of 1994 requires the BOP (subject to the availability of funds) to provide residential substance abuse treatment to all eligible inmates.

In fiscal year 2008, 17,523 inmates participated in the RDAP. This number represented 93 percent of the Federal inmate population that was eligible for treatment. This is the second year that the BOP was not able to meet the law's 100-percent treatment requirement due to insufficient funding. (Last fiscal year, the BOP provided residential drug abuse treatment to 80 percent of eligible inmates before their release from custody.)

The BOP believes that, without additional funding, the agency will unable to meet the law's mandate of treating 100 percent of eligible inmates for fiscal year 2009 and future years.

The last funding increase dedicated to an expansion of the RDAP was in 2003. At that time, the RDAP waiting list averaged 6,000 inmates. Today, the RDAP waiting list averages more than 7,600 inmates.

Providing an Early Release

Federal law allows the BOP to grant a non-violent offender up to 1 year off his/her term of imprisonment for successful completion of the Residential Drug Abuse Treatment Program (Title 18 U.S.C. § 3621(e)(2)). In fiscal year 2008, 4,800 inmates received a reduction in their term of imprisonment based on this law. Since the implementation of this provision in June 1995, a total of

32,618 inmates have received such a reduction.

In fiscal year 2008, eligible inmates received an average reduction in their term of imprisonment of 7.6 months. Inmates are receiving reductions that are less than 12 months due to the growing RDAP waiting list. Because of the demand, inmates are not being admitted to the program with sufficient time left on their sentence to allow for completion of all components of the program and to have 12 months remaining.

Coordinating with the Department of Health and Human Services

In fiscal year 2008, the BOP continued to work closely with the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Drug Abuse (NIDA), and the Office of Justice Programs in the development of protocols to facilitate treatment for substance-abusing inmates during each stage of the criminal justice system, from arrest to parole.

The *Federal Consortium to Address the Substance Abusing Offender* was established and funded by the Bureau of Justice Assistance (BJA) as the mechanism to facilitate this collaboration. The consortium includes representatives from many parts of the Federal criminal justice system, as well as representatives from the Department of Health and Human Services, the Department of Housing and Urban Development, the Department of Education, the National Highway Traffic Safety Administration, and the Centers for Disease Control and Prevention. The consortium works to develop information for State and local officials to assist with effective treatment protocols, communication and reporting strategies, data collection, and research.

The BOP continues to work closely with NIDA's Criminal Justice-Drug Abuse Treatments (CJ-DATS) and CJ-DATS II, as grantees continue in their assessments of drug abuse treatment programs. The eight University-based CJ-DATS grantees conduct their research in institutions and community corrections sites across the United States. The BOP has been working

with the Texas Christian University's Institute for Behavioral Research for the last 6 years in the testing of a program participant assessment protocol that provides drug abuse treatment staff with information on an inmate's progress in the RDAP. The instrument (known as the Criminal Justice - Client Evaluation of Self and Treatment) is designed to monitor individual inmate treatment improvements, program quality, and staff training needs.

In fiscal year 2008, the BOP continued its work with other CJ-DATS grantees, including the University of Kentucky and the National Drug Research Institute. These grantees view the BOP as having developed a model reentry program (one that includes drug abuse treatment as a component of reentry).

The BOP coordinates with NIDA, BJA, and SAMHSA to develop programs to improve the management and treatment of offenders with substance abuse and mental health disorders. Examples of improved management and treatment include: the development of gender-specific treatment protocols, the development of new systems for the clinical case management of offenders in the reentry process, the development of strategies to incorporate desistance, the development of enhanced quality assurance measures and methods, and the continuation of work to foster the use of technologies that facilitate communication among the various criminal justice entities.

Due to the increasing number of sex offenders with a drug use disorder and the enactment of the Adam Walsh Child Protection and Safety Act of 2006, which calls for the civil commitment of dangerous sex offenders, the BOP is coordinating with other Federal agencies and non-profit organizations to assess the development of a residential treatment program for individuals committed to the BOP under this civil commitment statute. Intervening and treating both disorders at the same time will provide some beneficial results for drug-disordered sex offenders committed to BOP custody.

Attachment I

DEFINITION OF DRUG USE DISORDERS: DEPENDENCE AND ABUSE

CRITERIA FOR SUBSTANCE DEPENDENCE: A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period.

(1) tolerance, as defined by either of the following:

(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect or

(b) markedly diminished effect with continued use of the same amount of substance.

(2) withdrawal, as manifested by either of the following:

(a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for withdrawal from the specific substance), or

(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

(3) the substance is often taken in larger amounts or over a longer period than was intended.

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use.

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.

(6) important social, occupational, or recreational activities are given up or reduced because of substance use.

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

CRITERIA FOR SUBSTANCE ABUSE: A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring at any time in the same 12-month period.

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).

(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).

(4) continued substance use despite having persistent or recurrent social or inter-personal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

Taken from the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV. Fourth Edition. American Psychiatric Association, 1994.

Attachment II

INMATE PARTICIPATION IN DRUG ABUSE TREATMENT PROGRAMS (Fiscal Years 1990 - 2008)

PROGRAM	1990	1991	1992	1993	1994*	1995	1996	1997	1998	1999	2000	2001	2002
Drug Abuse Education	5,446	7,644	12,500	12,646	11,592	11,681	12,460	12,960	12,002	12,202	15,649	17,216	17,924
Non-Residential Drug Abuse Treatment			654	1,320	1,974	2,136	3,552	4,733	5,038	6,535	7,931	10,827	11,506
Residential Drug Abuse Treatment	441	1,236	1,135	3,650	3,755	4,839	5,445	7,895	10,006	10,816	12,541	15,441	16,243
Community Transition Drug Abuse Treatment			123	480	800	3,176	4,083	5,315	6,951	7,386	8,450	11,319	13,107

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Drug Abuse Education	20,930	22,105	22,776	23,006	23,596	23,230	297,565
Non-Residential Drug Abuse Treatment	12,023	13,014	14,224	13,697	14,392	14,208	137,764
Residential Drug Abuse Treatment	17,578	18,278	18,027	17,442	17,549	17,523	199,840
Community Transition Drug Abuse Treatment	15,006	16,517	16,603	16,503	15,432	15,466	156,717

* In fiscal year 1994, the drug abuse education policy changed to allow for a waiver if an inmate volunteered for and entered the residential drug abuse treatment program. In addition, data for community transition drug abuse treatment was tabulated by average daily population.

Attachment III

RESIDENTIAL DRUG ABUSE TREATMENT PROGRAM LOCATIONS

NORTHEAST REGION
FCI Danbury (CT)✳
FCI Elkton (OH)
FCI Fairton (NJ)
FCI Fort Dix (NJ)
FPC Lewisburg (PA)
FPC McKean (PA)

MID-ATLANTIC REGION
FPC Alderson (WV)✳
FPC Beckley (WV)
FCI Beckley (WV)
FCI Butner (NC)
FPC Cumberland (MD)
FCI Cumberland (MD)
FMC Lexington (KY)★
FCI Morgantown (WV)
FCI Petersburg (VA)

SOUTHEAST REGION
FCI Coleman (FL)
FPC Edgefield (SC)
FCI Jesup (GA)
FCI Marianna (FL)
FPC Miami (FL)
FPC Montgomery (AL)
FPC Pensacola (FL)
FPC Talladega (AL)
FCI Tallahassee (FL)✳
FCI Yazoo City (MS)

NORTH CENTRAL REGION
FPC Duluth (MN)
FCI Englewood (CO)
FPC Florence (CO)
FCI Florence (CO)
FPC Greenville (IL)✳
FPC Leavenworth (KS)
FCI Leavenworth (KS)
FCI Milan (MI)
FCI Oxford (WI)
FCI Sandstone (MN)
MCFP Springfield (IL)★
FCI Waseca (MN)✳
FPC Yankton (SC)

SOUTH CENTRAL REGION
FCI Bastrop (TX)
FPC Beaumont (TX)
FCI Beaumont (TX)
FPC Bryan (TX)✳
FMC Carswell (TX)✳★
FSL El Paso (TX)
FCI El Reno (OK)
FCI Fort Worth (TX)
FPC Forrest City (AR)
FCI Forrest City (AR)
FCI La Tuna (TX)
FCI Seagoville (TX)
FPC Texarkana (TX)

WESTERN REGION
FCI Dublin (CA)✳
FPC Dublin (CA)✳
FPC Lompoc (CA)
FPC Phoenix (AZ)✳
FCI Phoenix (AZ)
FCI Sheridan (OR)
FPC Sheridan (OR)
FCI Terminal Island (CA)

CONTRACT FACILITY
RCI Rivers, (NC)

KEY
FCI = Federal Correctional Institution
FMC = Federal Medical Center
FPC = Federal Prison Camp
FSL = Federal Satellite (Low Security)
MCFP = Medical Center for Federal Prisoners
RCI = Rivers Correctional Institution
✳Female Facility
★Co-occurring Disorder Program